Name:_____ **Date of Birth:**_____

Diagnosis:_____

Allergies:_____

Medications:_____

Today's Date:_____ **Form Completed By:**_____

Please answer the following questions about your health and development so we can help with your needs.
(YOU always refers to the YOUNG PERSON)

Staff Only ***F/U***	**Staying Healthy** **Medical** **Home:**_____	**YES**	**SOME -TIMES**	**NO**
	1. Do you have a medical home (family doctor or clinic) that you go to when you are sick or need a check-up?			
	2. Do you have regular check-ups with your medical home provider?			
	3. Are you happy with your weight?			
	4. Do you exercise three times a week or more?			
	5. Do you brush your teeth at least daily?			
	6. Do you have a check-up with a dentist every year?			
	7. Do you have a soft formed bowel movement on a regular basis? (usually every other day)			
	8. Do you regularly use a seat belt?			
	9. Do you understand the changes that are happening to your body?			
	10. Do you understand the dangers of smoking, drinking, and using drugs?			

Name:_____ ID #: _____

Staff Only ***F/U***	**Managing Your Own Healthcare** **Drugstore:_____**	**YES**	**SOME -TIMES**	**NO**
	11. Can you describe your health problem?			
	12. Can you explain how your health problem affects your daily life?			
	13. Do you feel that your identified needs are being met?			
	14. Are you learning when, how much, and why you take medications? (prescription and over-the-counter, like Tylenol)			
	15. Are you beginning to be responsible for taking your own medications?			
	16. Are you learning the side effects of your medications?			
	17. Are you able to get the medications, supplies, and/or equipment you need?			
	18. Is your family able to pay for your dental needs?			
	19. Do you know when you will be too old to keep seeing your current healthcare providers?			
Staff Only ***F/U***	**Being Independent**	**YES**	**SOME -TIMES**	**NO**
	20. Are you learning to take care of your personal needs?			
	21. Are you learning to do things around the house? (laundry, meal preparation)			
	22. Do you help around the house? (chores, babysitting)			

Name:_____ ID #: _____

	23. Are you satisfied with how you are able to get around?			

Staff Only ***F/U***	**Emotional Health**	**YES**	**SOME -TIMES**	**NO**
	24. Can you describe things that you are good at?			
	25. Do you know someone that you can talk with when you feel sad, nervous, or things aren't going well?			
	26. Do you have friends that you spend time with at least once a week?			
	27. Do you spend time doing things with your family at least once a week?			
Staff Only ***F/U***	**School & Work** **School:**_____ **Grade:**_____	**YES**	**SOME -TIMES**	**NO**
	28. Do you go to school regularly?			
	29. Do you think that your schoolwork is at the right level for you?			
	30. Are you doing well in school?			
	31. Does your school give you the necessary time and space to take care of your health needs? (like taking medications or having extra room for equipment)			
	32. Do you take part in planning your education? (like picking your classes)			
	33. Does someone at your school talk with you about your plans for the future?			

Name:_____ ID #: _____

	34. Do you have a volunteer or paying job? (like babysitting, yard work, tutoring other kids)			

Staff Only ***F/U***	**Commission Satisfaction**	**YES**	**SOME -TIMES**	**NO**
	35. Are you pleased with the care you receive at the Commission?			

What would you like to see done differently:

Check All Information You Would Like to Have:

- ❍ Assistance Programs
- ❍ Medicaid
- ❍ Social Security
- ❍ Sexual Development
- ❍ Counseling
- ❍ Transportation
- ❍ School
- ❍ Careers
- ❍ Independent Living
- ❍ Scholarships
- ❍ Colleges
- ❍ Vocational Rehabilitation

Your Comments:

STAFF USE ONLY:_____

Reviewed By:

Name:_____ ID #: _____

Initials	Signature	Date